August 10, 2005: Testimony of the Honorable Eleanor Holmes Norton

Testimony of the Honorable Eleanor Holmes Norton
Before the Department of Defense Base Closure and Realignment Commission
Hart Senate Office Building
Washington, DC
August 10, 2005Mr. Chairman, and Members of the Commission, thank you again for the opportunity to express the views of the District of Columbia regarding the BRAC staff and the Department of Defense recommendations before you. First, I will address the staff recommendation for a Joint Medical Command Headquarters for the Navy Bureau of Medicine, the Air Force Medical Command, the TRICARE Management Authority and the Office of the Army Surgeon General. Then I will briefly present new information to the Commission that further demonstrates the negative impact that closure of Walter Reed Army Medical Center would have on the emergency disaster response capabilities of the nation’s capital. Sitting with me today for the purpose of responding to any questions you may have on the Walter Reed issues are two experts. Dr. Gregg Pane, Director of the District of Columbia Department of Health, an expert on the emergency health care capabilities of our nation’s capital, who previously served as Chief Policy and Planning Officer for the Veterans Health Administration. Also joining me today is Mr. Robert Malson, who serves as the Chief Executive Officer of the District of Columbia Hospital Association and is the Association’s primary liaison with the federal and district Governments. Mr. Malson also serves as a member of the Secretary of Health and Human Services’ Advisory Council on Public Health Preparedness and on the Department of Homeland Security’s Critical Infrastructure Task Force.I. The Joint Medical Command Co-location Should Occur Only If Moved to BollingFirst, I turn to the staff recommendation of joint medical command co-location. As you know, the Navy Bureau of Medicine is currently located at the Potomac Annex and the Air Force Medical Command is located at Bolling Air Force Base, both in the District, and TRICARE and the Office of the Army Surgeon General are located in leased space in Virginia. There is already significant controversy in the National Capital Region concerning losses to the government of valuable personnel that BRAC consolidation would cause, and this new recommendation would unnecessarily exacerbate these personnel issues unless the consolidation at issue here is achieved with minimal movement of staff. We therefore agree with the Department of Defense that maintaining these units in their current facilities is preferable considering all the changes that would be necessary to create a joint command, not worth the savings and the potential loss of personnel. However, we recognize that the presumption of the BRAC exercise is consolidation and joint co-location, and thus, in the alternative, we would support the creation of a Joint Medical Command and co-locating that Command at a military installation in the District of Columbia, particularly Bolling Air Force base or co-locating at Bolling without a Joint Command in light of projected cost savings. Co-location at Bolling, where there is ample room to accommodate the influx of personnel, would remove the need for approximately 166,000 square feet of leased space in the National Capital Region and also would place the Joint Command at a facility with a higher military security ranking than the present leased locations in which two of the current facilities are located.However, as you know a decision about consolidating these branches into a Joint Command is beyond the purview of this Commission. We believe that it is telling that the Department of Defense, which has pressed consolidation as a major goal of 2005 BRAC, considered the option of co-location but did not recommend that option to the Commission. The Department did preliminarily determine (without the benefit of its own completed analysis of the matter) that in the absence of a single Command, co-location of the various units would not be cost effective. However, it is also our understanding that the Department of Defense’s Joint Medical Command Study is still actively reviewing the option of consolidation. We believe it would be premature to assume the outcome of the study or to pre-judge its results in this round. However, as we will demonstrate shortly, the benefits of co-location are realized in part even if the Department decides not to create a joint command, but merely chooses to locate the medical branches together in the same space. In particular, co-location of the various medical units, even without consolidation of the branches, could realize some cost savings for the Department.Co-location of the various units at a single location likely would create several benefits. Primarily, creation of a joint headquarters would use 166,000 square feet of current excess space capacity with approximately 3,300 jobs, now dispersed throughout the region, that would be located in a single facility. Second, co-location could produce myriad efficiencies, although a joint command would be necessary to get the maximum benefit, such as shared support staff, and common operating structures. Third, co-location might result in allowing the Potomac Annex, the current home of the Navy Bureau of Medicine, to be used by the District for economic development and tax-generating purposes. Fourth, both co-location and co-location with consolidation could realize some cost savings for the Department. A recent Cost of
Base Realignment Actions (COBRA) analysis presented by Commission staff has shown that co-location of the various medical units could generate an initial annual savings of $18 million and savings of $111 million over 20 years. Co-location with consolidation of the branches would add additional annual savings of $24 million for a total savings of approximately $400 million over 20 years, and would pay for itself in two years. Although these figures are based on an analysis assuming co-location at the Naval Medical Center in Bethesda, Maryland, we anticipate that co-location at Bolling would realize even greater savings then would be achieved by attempting to fit upwards of 400,000 more square feet on Bethesda’s already crowded campus. Bolling already is the location of the Air Force Medical Command and would be the preferable site for co-location. The present employees at Bolling would remain, thus generating savings, some immediate, and removing personnel losses to the government, disruption, dislocation and potential controversy for one of the four units. Employees now at the two Virginia sites could more easily reach Bolling than Bethesda, and co-location at Bolling would help to compensate for the already contemplated job losses there. Bolling also would make the most sense because it is closest to the Pentagon.We believe that co-location at Bethesda is not

entirely feasible. Not only is the amount of space at the Bethesda Naval campus limited, but there also is a pending recommendation for a joint extramural research center there, which itself would require 500,000 square feet. In addition, because of the space constraints, co-location at Bethesda likely would require the construction of a new parking deck to accommodate the influx of employees. The cost of this deck is estimated at upwards of $20 million, compared with the approximately $1 million to $2 million cost of expanding a black top parking lot at Bethesda, if other facilities already proposed move there. When the Department of Defense Infrastructure Executive Council voted in May of 2005 to retain the Uniformed Services University of Health Sciences (USUHS), it decided not to pursue co-location of the medical branches under discussion. Although no analysis was available, nevertheless we understand that the issues we have raised and cost considerations contributed to the Department’s articulated concerns regarding the potential costs of co-location and the decision not to recommend co-location. We recommend that if, in spite of the Department of Defense our conclusion to the contrary, you decide that co-location is appropriate, co-locating these units in the District of Columbia would be the most rational and efficient option. II. Substantial Homeland Security Risks of Moving Walter Reed That Affect Military Value to the Nation’s CapitalIt has become necessary to bring to your attention information concerning the proposed closing of Walter Reed Army Medical Center in the nation’s capital that is critical to the application of the Commission’s military value criteria. According to all the available evidence, moving Walter Reed Army Medical Center would present a significant and potentially fatal risk to federal officials, employees and military personnel at bases located in the District as well as employees residents, visitors, tourists and others conducting business within the city limits. Unlike any other municipality in the nation, the District of Columbia is a federal city, and its emergency response planning is uniquely focused on protecting the city’s critical role as the center of this country’s federal government activity. I have attached to my testimony a memorandum to the Mayor of the District of Columbia from the Director of Health, Dr. Pane. Much of the information in his memo is incorporated into my testimony, but we thought you should also have Dr. Pane’s direct expert views. His memo addresses the relationship between Walter Reed and the District’s emergency response plan and shows the necessity for Walter Reed’s leadership, personnel, capacity and resources in the event of a major terrorist attack on the nation’s capital.We again stress that the statutory BRAC criteria clearly identify homeland security mission as a key consideration in evaluating the military value of the Department of Defense facilities. That mission is undercut if Walter Reed is moved to Bethesda.Walter Reed is an essential and integral component of the Emergency Preparedness Plan for the nation’s capital. The army hospital is located just 5 ½ miles from the White House, 6 ½ miles from the Capitol, 6 miles from the Washington Convention Center, and is strategically located just outside of the major commercial and government centers of the District. When surge capacity is needed in the District’s medical capacity, Walter Reed is poised to provide critical emergency response services to the President, Members of Congress, over 200,000 federal workers and military personnel, residents of the District and thousands of visiting tourists and others who work here.As part of the Hospital Emergency Preparedness Plan for the District, the federal Health Resource and Services Administration has requested that the District establish a system allowing the triage, treatment and initial stabilization of 500 adult and pediatric patients per million habitants, with acute illnesses or trauma requiring hospitalization from a chemical, biological, radiological, nuclear or explosive incident. This is above the current daily staffed bed capacity of the District, and needs Walter Reed’s available resources in order to comply with this Department of Homeland Security mandate.Walter Reed Army Medical Center is a full member of the DC Hospital Association (DCHA) maintaining extensive Memoranda Of Understanding with all District hospitals and participating in the HMARZ Radio Notification System. Because of their expertise, medical personnel from Walter Reed have routinely served in leadership positions within the DC Hospital Association. The Emergency Department Director of Walter Reed is the current co-chair of the DCHA Emergency Preparedness Subcommittee. Walter Reed personnel currently also serve as Co-chair of the Infectious Disease Subcommittee.Walter Reed Army Medical Center staff continues to participate in competency-based training offered by the Emergency Health and Medical Services Administration (EHMSA) in the District Response Plan, Weapons of Mass Destruction Plan, Disease Surveillance Plan, and other related programs. Walter Reed is a critical component of the surge bed capacity grid, providing beds for adults and children within 3 hours, 24 hours and 48 hours after incident.The Health Resource and Services Administrator grant also requires that the District ensure all participating hospitals have the capacity to maintain, in negative pressure isolation, at least one suspected case of a highly infectious disease (e.g., small pox, pneumonic plague, SARS, Influenza, Ebola and other hemorrhagic fevers) or any febrile patient with a suspect rash or other symptoms of concern who might possibly be developing a potentially highly communicable disease. The Department of Health needs every negative pressure isolation room and decontamination facility that Walter Reed has to offer in order to respond to a Weapons of Mass Destruction (WMD) scenario. Walter Reed’s closure and our inability to access the tremendous capabilities available at this facility would severely handicap these plans to serve the military and homeland security purposes in the District of Columbia. Walter Reed provides the fastest and most reliable ramp-up and surge capacity system in the District. The use of Walter Reed’s heliport for rapid deployment of antibiotics and other medical equipment and supplies if the Strategic National Stockpile has to be deployed is essential. The heliport is also part of the Department of Health’s Bioterrorism Response Plan.Closing Walter Reed would not only render the District non-compliant with federal Emergency Preparedness Plans, moving the hospital further from the nation’s capital also would place the nation’s capital at significantly greater risk in case of a terrorist attack requiring well-organized and effective emergency response system. The increased distance alone that hospital emergency personnel and first responders would have to travel over congested highways is even greater to reach downtown, where federal officials and employees are concentrated, than the miles involved suggest, considering the suburban congestion here that ranks among the highest in the nation. No other facility outside of the borders of the District – including new facilities at Bethesda and Fort Belvoir – can provide the same level of protection to the nation’s capital. Walter Reed could not

continue to provide this capability at Bethesda, because only the tertiary care capabilities are being moved to Bethesda. If Walter Reed’s critical resources were dispersed to Bethesda and to the new Dewitt Hospital more than twenty miles away at Fort Belvoir, medical personnel would be required to travel a significantly greater distance to make them useful in an emergency.It is clear that the Department did not adequately consider the relationship between the health functions and the homeland security specialties of Walter Reed in evaluating its military value. On point is new information that the Department of Defense itself apparently had not completed or perhaps had not even started at the time of its recommendations. Recent news reports reveal ongoing efforts by the Department of Defense Northern Command (NORTHCOM) to prepare our armed forces to meet new homeland security challenges. This past Monday, August 8, 2005, the Washington Post reported that the U.S. military has devised the first-ever war plans for guarding against and responding to terrorist attacks in the United States, envisioning fifteen potential crisis scenarios and anticipating several simultaneous strikes around the country. NORTHCOM’s draft plans would ready U.S. forces for domestic deployment to assist local first-responders in managing large-scale attacks that would almost certainly overwhelm many local emergency capabilities. Senior Defense officials have acknowledged the likelihood that the military will have to take charge in some situations – particularly in mass casualty situations and particularly where only the military could provide the necessary capacity and expertise. We believe that in the event of a terrorist attack in the nation’s capital, the likely need of the leadership and the use of medical personnel and facilities at Walter Reed would be indispensable considering the leadership role that Walter Reed personnel now plays in the homeland defense of the city.The Post article says that the NORTHCOM strategy would provide a “dual use” approach by training troops to serve both homeland and traditional military assignments. This “dual use” approach is precisely the role that Walter Reed Army Medical Center plays in the current emergency response capabilities of the nation’s capital.Defense Department planners at Northern Command Headquarters on the one hand cannot prepare for future homeland security missions, while the Department’s BRAC planners simultaneously take steps to dismantle Walter Reed and terminate the critical homeland security medical role Walter Reed would assume for our Nation’s Capital.The Department’s BRAC planners were apparently not aware of NORTHCOM’s homeland security study that is still in progress. However, to meet the requirements of law and the Commission’s own guidelines, the BRAC process must take into account the homeland security implications of the closure of Walter Reed, and the serious impact that it will have on the security of our nation’s capital. We believe that Walter Reed needs substantial physical renewal. The most cost effective way to accomplish this need without harming its homeland security mission to the military value and without risking its iconic medical reputation is to do what hospitals routinely do – to modernize their facilities. This is not the place to lay out the details, but it is clear that the work can be done at the existing facility. With careful planning and perhaps the use of swing space, work that the General Services Administration and the Department of Defense understand in the substantial overhaul of federal sites they routinely do, it may be possible. We urge the Commission to give the homeland security mission of Walter Reed great weight in light of its military value because of its mission in the nation’s capital and to leave the hospital here in the nation’s capital.